Commonwealth of Massachusetts
Executive Office of Health and Human Services

December 2011 *Version 4.3*

Companion Guide

Health Care Payment/Advice

ASC X12N 835 (Version 005010A1)

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1.0 Introduction

1.1 What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires MassHealth and all other health-insurance payers in the United States to comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services (HHS).

The standard adopted by HHS, effective January 1, 2012, for electronic health care transactions is ANSI ASC X12N Version 005010. The unique version/release/industry identifier code for the 835 Health Care Payment/Advice transaction is 005010X221A1.

1.2 Purpose of the Implementation Guide

The implementation guide specifies in detail the required formats for transactions submitted electronically to an insurance company, health-care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their submitters. It is critical that your IT staff or software vendor review this document in its entirety and follow the stated requirements to submit HIPAA-compliant files to MassHealth.

1.3 How to Obtain Copies of the Implementation Guides

The Implementation Guides for X12N, and all other HIPAA standard transactions, are available electronically at http://www.wpc-edi.com/.

1.4 Purpose of This Companion Guide

MassHealth created this companion guide for MassHealth trading partners to supplement the X12N Implementation Guide. This guide contains MassHealth-specific instructions related to the following:

- data formats, content, codes, business rules, and characteristics of the electronic transaction;
- technical requirements and transmission options; and
- information on testing procedures that each trading partner must complete before submitting electronic transactions.

The information in this document supersedes all previous communications from MassHealth regarding this electronic transaction. The following standards are in addition to those outlined in the MassHealth provider manuals. These standards in no way supersede MassHealth regulations. Use this guide in conjunction with the information found in the MassHealth provider manuals.

1.5 Intended Audience

The intended audience for this document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions. In addition, this information should be shared with the provider's billing office to ensure that all accounts are reconciled in a timely manner.

2.0 Establishing Connectivity with MassHealth

All MassHealth trading partners are required to sign a trading partner agreement (TPA). If you have elected to use a third party to perform electronic transactions on your behalf, you will also be required to complete a trading partner profile (TPP). If you have already completed these forms, you will not be required to complete them again. Please contact MassHealth Customer Service at 1-800-841-2900, or via e-mail at edi@mahealth.net (refer to Section 2.5 - Support Contact Information) if you have any questions about these forms.

2.1 Setup

MassHealth trading partners should submit electronic health care transactions to MassHealth via the Provider Online Service Center (POSC) or system-to-system using our Healthcare Transaction Service (HTS) process.

After establishing a transmission method, each trading partner must successfully complete testing. Information on this phase is provided in the next section of this companion guide (refer to Section 2.2 - Trading Partner Testing). After successful completion of testing, transactions may be submitted for production processing.

2.2 Trading Partner Testing

Before submitting production transactions to MassHealth each trading partner must complete testing. All trading partners who plan to submit transactions must contact MassHealth Customer Service at 1-800-841-2900 in advance to discuss the testing process, criteria, and schedule. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

The following conditions must be addressed in one or more test files.

- Providers with no claims on an 835 will not have any CLP segments.
- Providers with professional claims and institutional claims that are adjudicated at the claim service line level will note 2110 loops on the 835, due to adjudication at the detail level. MMIS reports a single claim with multiple service lines as one CLP (loop 2100) and multiple SVC (loop 2110).
- Providers with inpatient claims will note on the 835 that there is no 2110 CAS segment due to adjudication at the header level.

MassHealth will send all fully adjudicated claims from a weekly cycle in one ST/SE segment, even if the number of CLP segments exceeds 10,000.

This limit of 10,000 CLP segments is a recommendation for the 835 transaction, but not a requirement. Trading partners, especially those handling a large claim volume, are encouraged to proactively test their compliance software internally to ensure it allows over 10,000 CLP segments in one 835 transaction.

Each 835 transaction is sent in a separate ISA/IEA envelope. For clearinghouses with multiple providers, multiple ST/SEs will be generated under the same ISA/IEA. For example, if a clearinghouse has been selected to receive three of their clients' 835s, the structure will be as follows:

- ISA Clearinghouse 123
- GS Clearinghouse 123
- ST Provider A
- SE
- ST Provider B
- SE
- ST Provider C
- SE
- GE
- IEA

The 835 files will be available for trading partners to download from the POSC for at least 180 days. Trading partners requiring access to their 835s beyond the 180-day period should contact MassHealth Customer Service. (See Section 2.2 – Support Contact Information.)

The 835 transaction is available to those trading partners with a signed TPA on file. 835 transactions are generated at the completion of each weekly claims adjudication cycle for each provider with at least one paid or denied claim appearing in the weekly cycle or other financial activities. Information about pended or suspended claims can be obtained from the MassHealth proprietary remittance advice, which can be found on the POSC or via requesting the 276 Claims Status Inquiry and Response transactions. Since an 835 transaction must balance to a single check/electronic funds transfer (EFT), MassHealth is obligated to include all fully adjudicated claims from a weekly cycle, regardless of how the claim was submitted (POSC, paper, or as an 837 transaction). As usual, the State Comptroller sends the payment check or EFT separately.

835s are generated based on the TPA that the provider has submitted to MassHealth. If the provider has chosen to receive 835s for all associated PID/SLs to a designated PID/SL within the group, MassHealth will send all 835s to that PID/SL by indicating a different PID/SL in the ST segment. If the provider has chosen to receive individual 835s for all PID/SLs in the TPA, all providers will receive 835s for their PID/SL.

2.2.1 Payment and Remittance Schedule

835s are available for retrieval each week.

2.2.2 835 Transactions in Response to Retail Pharmacy Claims

Retail pharmacy providers will receive their payment and 835 from MassHealth. Although MMIS does not accept pharmacy claims, the adjudicated pharmacy claim information is received from the POPS vendor, to subsequently be included in the MMIS financial process.

It is from this information that the MMIS 835 for pharmacy claims is generated. Information about the contents in the retail pharmacy 835 transaction can be requested via e-mail to MassHealth.Providerrelations@acs-inc.com or by calling 617-423-9830.

2.2.3 Retroactive Pay Cycles

When a retro cycle produces a separate payment from the regular weekly claims run, a separate 835 transaction is also produced.

2.2.4 Production File-naming Convention

835 files produced by MassHealth have the following naming convention:

XXXXXXXXXX.835.WEB.hhmmssnnn.jjj, where

- XXXXXXXXXX is the trading partner's MMIS PID/SL;
- hhmmss is the time stamp;
- nnn is the sequence number; and
- jjj is the Julian day.

2.2.5 MassHealth CLP Segment Implementation

835s can also be generated without any CLP and SVC. This will be the 835 for providers with no claim activity, but with provider level adjustments. An 835 transaction has one loop 1000A, one loop 1000B, multiple iterations of loop 2000*, multiple iterations of loop 2100*, and multiple iterations of loop 2110*.

MassHealth denies claims with the header submitted charges not matching the total detail submitted charges. These claims will be reported on 835 with only the header information (a CLP segment with a CAS segment offsetting the billed amount) and no SVC data.

If the sum of the claim payment amounts (CLP04s) on the 835 transaction is positive, then a check or EFT payment is produced. One check or one EFT payment must balance to one 835 transaction. As a result, each 835 can have only one ST and SE segment. MassHealth produces all of a provider's paid and/or denied claims in a weekly cycle in one ST/SE segment, even if the number of CLP segments exceeds 10,000.

If the sum of the claim payment amounts (CLP04s) on the 835 is zero or negative, no check or EFT payment is sent. The 835 is still produced, but the financial fields are zero filled, as they will not be applicable.

***If there is only one fully adjudicated claim for a provider, then there will be only a single iteration of this segment.**

2.3 Technical Requirements

Please note that the POSC does not zip or compress files. All files are transmitted in an unzipped or uncompressed format.

2.4 Acknowledgements

MassHealth does not require an acknowledgment and will ignore the receipt of any 999 transactions.

2.5 Support Contact Information

For questions about any issues in this companion guide, providers may contact MassHealth Customer Service by mail, phone, fax, or e-mail.

(For written correspondence)

MassHealth Customer Service
P.O. Box 9118
Hingham, MA 02043-9118

(Use this MassHealth address only for electronic claims.)

MassHealth Customer Service
75 Sgt. William B. Terry Dr.
Hingham, MA 02043-1545

Phone: 1-800-841-2900
Fax: 617-988-8971
E-mail: edi@mahealth.net

2.6 Additional Information for Member Name

The member name submitted with a claim can be up to 60 characters for the last name and 35 characters for the first name. 2100 patient name segment will report the last and first name as submitted with the claim. 2100 corrected patient/insured name is only reported when the submitted name is different from the one stored in the MMIS database.

2.7 Additional Information for Dental Providers

Dental providers submitting both dental and medical claims will receive their payment and 835 from MassHealth. Adjudicated dental claim information is received from DentaQuest, a third party vendor, to subsequently be included in the MassHealth financial process. It is from this information that the MassHealth 835 for dental claims is generated. If a provider submits both dental and medical claims, they will access their 835 transaction from MassHealth. If a provider submits only dental claims, the 835 is distributed by DentaQuest. These providers should work with DentaQuest to establish connectivity to receive their 835 transaction.

Support contact information for DentaQuest is as follows.

DentaQuest/MassHealth Dental Program
12121 N. Corporate Parkway
Mequon, WI 53092
Phone: 1-800-207-5019
E-mail: eclaims@masshealth-dental.net
Web site: www.masshealth-dental.net

3.0 MassHealth-Specific Requirements

The following section outlines the specifications for the 835 transaction. This information is provided to assist trading partners in using the reported data for reconciliation of claims and financial adjustments in their system.

3.1 Interchange Control and Functional Group Header Values

Loop	Segment		Segment Name	Element Name	Companion Information
----	ISA	01	----	Authorization Information Qualifier	00
----	ISA	02	----	Authorization Information	10 blanks
----	ISA	03	----	Security Information Qualifier	00
----	ISA	04	----	Security Information	10 blanks
----	ISA	05	----	Interchange ID Qualifier	ZZ
----	ISA	06	----	Interchange Sender ID	DMA7384
----	ISA	07	----	Interchange ID Qualifier	ZZ
----	ISA	08	----	Interchange Receiver ID	Trading partner ID assigned by MassHealth OR 10-digit MMIS provider ID/service location (PID/SL).
----	ISA	09	----	Interchange Date	Format is YYMMDD.
----	ISA	10	----	Interchange Time	Format is HHMM.
----	ISA	11	----	Repetition Separator	Value = ^
----	ISA	12	----	Interchange Control Version Number	Value = 00501
----	ISA	13	----	Interchange Control Number	Identical to the associated interchange control trailer, IEA02
----	ISA	14	----	Acknowledgement Requested	0
----	ISA	15	----	Usage Indicator	P = Production data T = Test data
----	ISA	16	----	Component Element Separator	Value = :

Loop	Segment		Segment Name	Element Name	Companion Information
----	GS	01	----	Functional Identifier Code	HP
----	GS	02	----	Application Sender's Code	DMA7384
----	GS	03	----	Application Receiver's Code	Trading partner ID assigned by MassHealth OR 10-digit MMIS provider ID/service location (PID/SL)
----	GS	04	----	Date	Format is CCYYMMDD.
----	GS	05	----	Time	Format is HHMM.
----	GS	06	----	Group Control Number	Identical to the associated functional group trailer, GE02
----	GS	07	----	Responsible Agency Code	X
----	GS	08	----	Version/Release/ Industry Identifier Code	Value = 005010X221A1

3.2 Common Segment Values

Loop	Segment		Segment Name	Element Name	Companion Information
Header	ST	02	Transaction Set Header	Transaction Set Control Number	MMIS will auto-fill this field. ST02 is a sequential number starting with 1.
Header	ST	03	Transaction Set Header	Implementation Convention Reference	Not used

3.3 Common Detail Values

Loop	Segment		Segment Name	Element Name	Companion Information
Header	BPR	01	Financial Information	Transaction Handling Code	When the total payment amount (BPR02) is greater than zero, BPR01 contains **I (remittance information only).** When the total payment amount (BPR02) is zero, BPR01 contains an **H** (**notification only).** For state transfers, this will always be H.
Header	BPR	04	Financial Information	Payment Method Code	This will be populated with "ACH" when BPR01 equals I. This will be populated with "NON" when BPR01 equals H.

Loop	Segment		Segment Name	Element Name	Companion Information
Header	BPR	05	Financial Information	Payment Format Code	For providers receiving payments electronically, this is CTX (corporate trade exchange).
Header	BPR	11	Financial Information	Originating Company Supplemental Code	This field is used by MassHealth for tracking purposes to assist in issue resolution. It is populated with a voucher number from MMARS.
Header	REF	02	Receiver Identification	Receiver Identifier	This data element is used only when the payee is not the same as the receiver of the 835. MassHealth returns the 835 receiver's MassHealth-assigned provider ID/service location you provided on your Trading Partner Profile form.
Header	DTM	01	Production Date	Date/Time Qualifier	This field will always contain the value of 405 for production.
Header	DTM	02	Production Date	Date	This attribute is also known as the financial run date. The run date is calculated based on the system date in which the financial cycle was initiated.
1000A	N1	02	Payer Identification	Name	This value is always Commonwealth of Massachusetts/EOHHS/Office of Medicaid.
1000A	PER	03	Payer Business Contact Information	Communication Number Qualifier	TE
1000A	PER	04	Payer Business Contact Information	Payer Business Contact Communication Number	The phone number on the 835 will be for MassHealth Customer Service. However, if the questions are about a pharmacy claim, use the ACS phone number (617-423-9830). If questions are about a Dental claim, use the Doral phone number (1-800-207-5019).
1000A	PER	05	Payer Business Contact Information	Communication Number Qualifier	EM
1000A	PER	06	Payer Business Contact Information	Payer Business Contact Communication Number	The e-mail on the 835 will be for MassHealth Customer Service: edi@mahealth.net. However, if the questions are about a Pharmacy claim, use the ACS e-mail: MassHealth.ProviderRelations@acs-inc.com.

Loop	Segment		Segment Name	Element Name	Companion Information
1000A	PER	01	Payer Technical Contact Information	Contact Function Code	BL
1000A	PER	02	Payer Technical Contact Information	Payer Technical Contact Name	EOHHS Customer Service
1000A	PER	03	Payer Technical Contact Information	Technical Communication Number Qualifier	TE
1000A	PER	04	Payer Technical Contact Information	Technical Communication Number	1-800-841-2900
1000A	PER	05	Payer Technical Contact Information	Technical Communication Number Qualifier	UR
1000A	PER	06	Payer Technical contact Information	Technical Communication Number	hipaasupport@mahealth.net
1000A	PER	01	Payer Web Site	Contact Function Code	IC
1000A	PER	03	Payer Web Site	Web Site Communication Number	UR
1000A	PER	04	Payer Web Site	Communication Number	www.mass.gov/masshealth
1000B	N1	03	Identification Code	Identification Code Qualifier	MassHealth returns national provider ID (XX in 1000B:N103) when the NPI is returned in N104. MassHealth returns federal taxpayer's identification number (FI in 1000B:N103), when the provider tax ID is returned in N104.
1000B	N1	04	Identification Code	Payee Identification Code	MassHealth returns NPI. For an atypical provider, MassHealth returns provider tax ID.
1000B	N3	01	Payee Identification	Payee Address Line	In MMIS, this field is not used. Therefore, the billing address on file will not be returned.
1000B	N4	01	Payee City, State, Zip Code	City Name	In MMIS, this field is not used. Therefore, the billing address on file will not be returned.
1000B	N4	02	Payee City, State, Zip Code	State	
1000B	N4	03	Payee City, State, Zip Code	Zip Code	

Loop	Segment		Segment Name	Element Name	Companion Information
1000B	REF	01	Payee Additional Identification	Reference Identification Qualifier	TJ - Federal taxpayer's identification number (NPI) is reported when NPI is reported in 1000B:N104 and if available in MMIS. PQ - Payee identification is reported for atypical providers (1000B:N104 = federal tax ID).
1000B	REF	02	Payee Additional Identification	Additional Payee Identifier	MassHealth returns the federal tax payer's identification number when 1000B:N104 equals NPI. MassHealth returns MMIS provider ID/SL when the provider tax ID was used in 1000B:N104 (for atypical providers).
2100	CLP	01	Claim Payment Information	Patient Control Number	**For EDI 837 submitted claims** MassHealth would return the data in loop 2300 CLM01 of the 837. **For paper and direct data entry (DDE) claims** MassHealth returns the patient control number or the patient account number. If this field is left blank on the incoming claim, then we return zeros. For pharmacy claims, the prescription number will be reported.
2100	CLP	02	Claim Status Code	Claim Status Code	**Code** **Description** 1 Claim processed as primary 2 Claim processed as secondary 3 Claim processed as tertiary 4 Claims denied with edit 2001 indicating patient/subscriber billed is not known 22 Reversal of previous payment
2100	NM1	03	Patient Name	Patient Last Name	For claims received on an 837, MassHealth returns the patient name information that you provided in Loop 2010BA NM103, NM104, NM105, and NM107.
2100	NM1	04	Patient Name	Patient First Name	

Loop	Segment		Segment Name	Element Name	Companion Information
2100	NM1	05	Patient Name	Patient Middle Name	**For paper and direct data entry (DDE) claims** MassHealth returns the patient name information that we have on file in our claims processing system. If the member number that you provide does not find a match in our system, MassHealth populates the member last name (NM103) and member first name (NM104) data elements with "name missing."
2100	NM1	03	Corrected Patient/Insured Name	Corrected Patient Last Name	This segment is populated when there is a discrepancy in the name information submitted on the claim (NM1) and the MMIS member database. This will be done for paper and electronic submissions.
2100	NM1	04	Corrected Patient/Insured Name	Corrected Patient First Name	
2100	NM1	05	Corrected Patient/Insured Name	Corrected Patient Middle Name	
2100	NM1	03	Service Provider Name	Rendering Provider Last or Organization Name	For 837 claims, MassHealth returns the claim level rendering provider information as submitted on the claim. For paper and DDE claims, MassHealth returns the rendering provider's name on the database.
2100	NM1	04	Service Provider Name	Rendering Provider First Name	
2100	NM1	05	Service Provider Name	Rendering Provider Middle Name	
2100	NM1	07	Service Provider Name	Rendering Provider Name Suffix	
2100	NM1	03	Corrected Priority Payer Name	Name Last or Organization Name	This segment is populated to report the payer that caused the claim to deny with TPL edit. If multiple payers caused the claim to deny for TPL edit, MassHealth prioritizes the payer to be reported (Medicare takes priority). Carrier name is populated in NM103.
2100	NM1	08	Corrected Priority Payer Name	Identification Code Qualifier	**Code** **Description** PI Payer identification

Loop	Segment		Segment Name	Element Name	Companion Information
2100	NM1	09	Corrected Priority Payer Name	Identification Code	Carrier ID is populated here.
2100	REF	01	Other Claim Related Information	Other Claim Related Identifier	If applicable to the claim, MassHealth returns the following information. There may be zero to five iterations of this segment, depending on how many of the above criteria are met.
2100	REF	02	Other Claim Related Information	Other Claim Related Identifier	1. **Medical Record Number:** REF01 = EA REF02 = the inpatient or outpatient medical record number 2. **Social Security Number:** REF01 = SY REF02 = the member social security number 3. **Prior Authorization Number:** REF01 = G1 REF02 = the six-character prior authorization number 4. **Former ICN:** REF01 = F8 REF02 = the 10-character former TCN 2 5. **TPL Policy Number:** REF01 = 6P REF02 = The TPL policy number The group number of the other insured for the payer will be reported in the corrected priority payer name/identification code.
2100	AMT	01	Service Supplemental Amount	Amount Qualifier Code	**Code** **Description** AU Coverage amount
2100	AMT	02	Service Supplemental Amount	Monetary Amount	Allowed amount from the claim line
2100	AMT	01	Service Supplemental Amount	Amount Qualifier Code	**Code** **Description** F5 Patient paid amount
2100	AMT	02	Service Supplemental Amount	Monetary Amount	On a provider-submitted original claim, use the greater of provider submitted PPA or the PPA on our database.

Loop	Segment		Segment Name	Element Name	Companion Information
2100	DTM	01	Statement From or To Dates	Date/Time Qualifier	**Code** **Description** 232 Claim statement period start 233 Claim statement period end
2100	DTM	02	Statement From or To Dates	Date	Format is CCYYMMDD.
2100	DTM	01	Coverage Expiration Date	Date/Time Qualifier	36
2100	DTM	02	Coverage Expiration Date	Date	Format is CCYYMMDD.
2110	SVC	01-1	Service Payment Information	Composite Medical Procedure Identifier - Product/Service ID Qualifier	In order to provide the most detailed information to providers on why a claim denied, MassHealth supplies remark codes when applicable on all denied claims. To include remark codes, the 835 Implementation Guide mandates that we also provide service line information. The following is a list of defaults we use, if the incoming claim is missing this required data.
2110	SVC	01-2	Service Payment Information	Composite Medical Procedure Identifier - Product/Service ID	**Segment** **Value** **For 837 Dental claims** SVC01-1 ADA SVC01-2 Procedure code
2110	SVC	04	Service Payment Information	Product/Service ID	**For 837 Professional claims, a HCPCS code is provided** SVC01-1 HC SVC01-2 Service code **For certain 837 Institutional claims or claims received on a UB-04 form, a revenue code and no HCPCS is provided** SVC01-1 NU SVC01-2 Revenue code

Loop	Segment		Segment Name	Element Name	Companion Information
					For an 837 Institutional claim, or claims received on a UB-04 form – if HCPCS submitted, both a service and a revenue code are provided SVC01-1 HC SVC01-2 Service code SVC04 Revenue code **For Pharmacy claims** SVC01-1 N4 SVC01-2 National drug code in 5-4-2 format
2110	DTM	02	Service Date	Service Date	For paper claims submitted with an invalid date such as spaces or 20020231, we return 99990101.
2110	CAS	01	Claims Adjustment	Claim Adjustment Group Code	**Code Description** CO Contractual Obligations OA Other Adjustments PI Payer Initiated Reductions PR Patient Responsibility
2110	CAS	02	Claims Adjustment	Claim Adjustment Reason Code	Refer to Section 3.4 - Additional Information for Detail Values. Providers can refer to claim adjustment reason codes at http://www.wpc-edi.com/custom_html/claimadjustment.htm.
2110	CAS	03	Claims Adjustment	Monetary Amount	Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in SVC03 and CLP04.
2110	CAS	04	Claims Adjustment	Quantity	A positive number decreases paid units, and a negative value increases paid units.
2110	REF	01	Line Item Control Number	Reference Identification Qualifier	**Code Description** 6R Provider control number
2110	REF	02	Line Item Control Number	Reference Identification	For claims received on an 837, MassHealth returns the line item control number, which is used by the provider for tracking purposes.

Loop	Segment		Segment Name	Element Name	Companion Information
2110	REF	01	Rendering Provider Information	Reference Identification Qualifier	**Code** **Description** D3 National Council for Prescription Drug Programs pharmacy number HPI Provider NPI G2 Provider commercial number (used when the atypical provider PID/SL is reported)
2110	REF	02	Rendering Provider Information	Reference Identification	MassHealth returns the service level rendering provider information as submitted on the claim.
2110	AMT	01	Service Supplemental Amount	Amount Qualifier Code	**Code** **Description** B6 Allowed – Actual
2110	AMT	02	Service Supplemental Amount	Monetary Amount	Allowed amount from the service line
2110	LQ	01	Health Remark Codes	Code List Qualifier Code	**Code** **Description** HE Claim payment remark codes There are as many iterations of the LQ segment as needed to accommodate each unique remark code associated with the claim. When an EOB/remark code relates the header of the claim, the related header LQ segments will appear in each service line loop of the claim.
2110	LQ	02	Health Remark Codes	Industry Code	LQ02 will contain each unique remark code associated with the claim. Providers can refer to remark codes at http://www.wpc-edi.com/content/view/507/228.
Summary	PLB	03-1	Provider Adjustment	Adjustment Identifier/ Adjustment Reason Code	This segment is used only if there are non-claim related adjustments and/or adjustments made by MMARS. **Code** **Description** 72 Authorized return CT For capitation payment FB For forwarding balance IR Internal Revenue Service withholding LE Levy WO Overpayment recovery CS Adjustment- will be used to identify an adjustment applied to payment due to MMARS.

Loop	Segment		Segment Name	Element Name	Companion Information
Summary	PLB	03-2	Provider Adjustment	Adjustment Identifier / Reference Identification	All 9s will be populated here when a MMARS adjustment has been performed (PLB03-01 = CS).

3.4 Additional Information for Detail Values

3.4.1 Denied Claims: 2110/CAS - Claims Adjustment Details

Denied claims with prior payer paid amount equal to the billed amount will not report the other paid amount, but spread the denied amount across all reportable edits.

If a denied claim has a nonzero other paid amount, and the other paid amount is not equal to the billed amount, the other paid amount will be reported as an adjustment, and then the remaining dollars will be divided across all reportable edits.

If a denied claim has a nonzero other paid amount, the other paid amount is equal to the billed amount. The other paid amount will not be reported as an adjustment, and all the adjustment dollars will be divided across all reportable edits.

Here are examples of how this will work.

Claim 1:

Billed amount = $100.00
Other paid amount = $80.00
Denied edit codes cross-walked to adjustment reason codes AA and BB
Adjustments:
Other paid amount = $80.00
AA = $10.00
BB = $10.00

Claim 2:

Billed amount = $100.00
Other paid amount = $100.00
Denied edit codes cross-walked to adjustment reason codes AA and BB
Adjustments:
AA = $50.00
BB = $50.00

Claim 3:

Billed amount = $100.00
Other paid amount = $120.00
Denied edit codes cross-walked to adjustment reason codes AA and BB
Adjustments:
Other paid amount = $120.00
AA = -$10.00
BB = -$10.00

Table 1: Sample of MassHealth Edit Code Crosswalks

Current MassHealth Edit Code	Adjustment Reason Code	Remark Code
241	A1	M58
814	16	MA61
1055	52	M68
020	52	M68
6001	B13	N/A

CAS03, CAS06, etc.: MassHealth returns in CAS03, CAS06, etc., the difference between SVC03 and SVC02, divided by the number of adjustment reason codes associated with the claim. For example, assume claim segment SVC03 – SVC02 = $300.25 and the MMIS edits in Table 1 are generated. Since there are three unique adjustment reason code/remark code pairs, $300.25 is divided by 3. For the claim that generates edit codes 241, 814, 1055, and 020 in the above example, the CAS and the LQ segments on the 835 appear as follows.

CAS*CO*16*100.25**52*100**A1*100~
- LQ*HE*MA61~
- LQ*HE*M68~
- LQ*HE*M58~

Edit code 6001 has no LQ segment because it does not have a corresponding remark code. Edit code 020 has no CAS and LQ segments because it has the same adjustment reason code/remark code pair as edit code 1055, thus it is not reported twice.

3.4.2 Denied Claims without a CAS Segment

For denied claims that do not have a CAS segment (CLP03 = CLP04 and SVC02 = SVC03) there are as many iterations of the LQ segment as needed to accommodate up to 99 unique remark codes.

LQ01: LQ01 is always HE.
LQ02: In LQ02, MassHealth returns each unique remark code associated with the claim.

3.4.3 Default Dates

When an invalid date is submitted on the claim, or when a claim has a fatal error before the system is able to store the dates that were submitted on the claim, a default date of "19000101" will be coded on the 835 transaction for any date field.

4.0 Sample MassHealth Transactions

A. 5010 Loop change samples (Note underlined text within sample.):

1. 2100 AMT Allowed Amount
Sample 837I EDI shows the new AMT*AU allowed amount posted only for information.
Note: AMT*AU is not part balancing.

LX*1~
CLP*26010*4*1000*0*0*MC*2211219000001~
CAS*CO*133*333.34~
CAS*OA*23*333.33~
CAS*CO*45*333.33~
NM1*QC*1* LASTNAME*FIRSTNAME****MR*999999999999~
NM1*74*1* CORRECTEDLASTNAME*CORRECTEDFIRSTNAME~
DTM*232*20110601~
DTM*233*20110604~
AMT*AU*8145.63~

2. 2100 CAS Claim Adjustment Group Code
Sample 837P reversal ICN and a denied replacement ICN shows the new reversal qualifier OA reporting the CAS adjustment amount previously reported with qualifier CR.

CLP*772575536523300010 19*22*-130*-18.06*0*MC*2010102702533~
CAS*OA*B13*-111.94~
NM1*QC*1*LASTNAME*FIRSTNAME****MR*999999999999~
NM1*74*1*CORRECTEDLASTNAME*CORRECTEDFIRSTNAME~
REF*EA*000002195988~
REF*G1*S000000001~
DTM*232*20100405~
DTM*233*20100405~
CLP*772575536523300010 19*4*130*0*0*MC*5911208001002
CAS*CO*B5*130~
NM1*QC*1*LASTNAME*FIRSTNAME****MR*100056666666~
NM1*74*1*CORRECTEDLASTNAME*CORRECTEDFIRSTNAME~
REF*EA*000002195988~
REF*G1*S000000001~
REF*F8*2010102702533 ~
DTM*232*20100405~
DTM*233*20100405~

3. 2100 DTM Claim Date Coverage Expiration Date
Sample denied ICN where denial is for member's coverage ended. The 835 displays the member's coverage end date in the DTM*036 line resulting in member denying for no open coverage on service date billed.

CLP*24622*4*155*0*0*MC*2011201700001~
NM1*QC*1*LASTNAME*FIRSTNAME****MR*999999999999~
NM1*74*1* CORRECTEDLASTNAME*CORRECTEDFIRSTNAME~
REF*EA*125~
DTM*232*20110712~
DTM*233*20110712~
DTM*036*19791231~
SVC*HC:99214*150*0**0**1~
DTM*472*20110712~
CAS*CO*31*150~
REF*6R*321~
REF*HPI*1821017195~
LQ*HE*N30~

B. 2100 CLP samples:

1. 2100 CLP Sample #1
Sample denied claim where the CLP02 / claim status = 1.
Prior to 5010 the CLP02 status would equal 4 for all denied claim records.

CLP*TEST WI 26768*1*155*0*0*MC*201128070999*11*1~
NM1*QC*1*LASTNAME *FIRSTNAME ****MR*999999999999~
REF*EA*125~
DTM*232*20110822~
DTM*233*20110822~
DTM*036*19791231~
SVC*HC:99214*150*0**0**1~
DTM*472*20110822~
CAS*CO*31*150~
REF*6R*321~
REF*HPI*1821017195~
LQ*HE*N30~
SVC*HC:82270*5*0**0**1~
DTM*472*20110822~
CAS*CO*31*5~
REF*6R*322~
REF*HPI*1821017195~
LQ*HE*N30~
SE*58*28001~
GE*1*28~
IEA*1*000000396~

2. 2100 CLP Sample #2
Sample denied claim for edit 2001/member not on file, where CLP02/claim status = 4.
This is the only denial edit reason that will result in a CLP02 status of 4 being moved to the CLP02 claim status field post 5010 implementation.

CLP*TEST WI 26768*4*155*0*0*MC*201128070999*11*1~
CAS*CO*31*155~
NM1*QC*1*LASTNAME *FIRSTNAME ****MR*999999999999~
REF*EA*125~
DTM*232*20110811~
DTM*233*20110811~
CLP*TEST WI 26768*1*155*0*0*MC*2011280700001*11*1~
NM1*QC*1*CHURCHILL*GARY****MR*100002040465~
REF*EA*125~
DTM*232*20110822~
DTM*233*20110822~
DTM*036*19791231~
SVC*HC:99214*150*0**0**1~
DTM*472*20110822~
CAS*CO*31*150~
REF*6R*321~
REF*HPI*1821017195~
LQ*HE*N30~
SVC*HC:82270*5*0**0**1~
DTM*472*20110822~
CAS*CO*31*5~
REF*6R*322~
REF*HPI*1821017195~
LQ*HE*N30~
SE*58*28001~
GE*1*28~
IEA*1*000000396~

3. 2100 CLP Sample #3
Sample paid claim where CLP02/ claim status = 1.

CLP*Defect 26686*1*155*77.1*0*MC*201128570999*11*1~
NM1*QC*1*D*Evelyn****MR*999999999999~
NM1*74*1*LASTNAME *FIRSTNAME~
REF*EA*125~
DTM*232*20110902~
DTM*233*20110902~
SVC*HC:99214*150*73.71**1~
DTM*472*20110902~
CAS*CO*45*76.29~
REF*6R*321~
REF*HPI*1821017195~
AMT*B6*73.71~
LQ*HE*N419~
SVC*HC:82270*5*3.39**1~
DTM*472*20110902~
CAS*CO*45*1.61~
REF*6R*322~
REF*HPI*1821017195~
AMT*B6*3.39~
LQ*HE*N419~

5.0 Version Table

Version	Date	Section/Pages	Description
4.0	04/2011	Entire document	Revisions for HIPAA version 5010. Revision-1 Complete revision due to CMS-mandated 5010 standards. All previous versions are obsolete.
4.1	08/2011	Section 3.3	2100 CLP02 - removed values 5, 17, 19, 20, 21, 23, 25, and 27 2100 CLP02 - revised description for values 1, 2, 3, and 4 Added 2100 DTM01/02 - Coverage Expiration Date Deleted 2100 DTM01/02 - Claim Date
4.2	10/2011	Section 4.0	Added sample MassHealth transactions
4.3	11/2011	Section 3.4.1	Clarified Denied Claims: 2110/CAS - Claims Adjustment Details

Appendix A: Acknowledgements

MassHealth does not require an acknowledgment and will ignore the receipt of any 999 transactions.

Appendix B: Frequently Asked Questions

Q. Do I have to receive an 835 remittance response if I submit my claims electronically?
A. No. You can submit an 837 transaction, but elect to not receive the 835 response. You will still receive the PDF remittance advice (as described above).

Q. Will any paper claims I submit also appear on the 835?
A. Yes. All paid and denied claims adjudicated in the weekly cycle will appear, regardless of how they were submitted.

Q: Will suspended and pended claims appear on the 835?
A: No. Suspended and pended claims will appear only on the PDF remit.

Q. Can I have my billing intermediary receive my 835?
A. Yes. You can, as long as you indicate that in your TPP information.

Appendix C: Links to Online HIPAA Resources

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains electronic data interchange (EDI) standards and related documents for national and global markets. www.x12.org

Accredited Standards Committee (ASC X12N)

- ASC X12N develops and maintains X12 EDI and XML standards, standards interpretations and guidelines as they relate to all aspects of insurance and insurance-related business processes. www.x12.org

American Hospital Association Central Office on ICD-9-CM (AHA)

- This site is a resource for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level I HCPCS. www.ahacentraloffice.org

American Medical Association (AMA)

- This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health-care Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/HIPAAGenInfo/
- This site is the resource for information related to the Health-care Common Procedure Coding System (HCPCS). www.cms.hhs.gov/HCPCSReleaseCodeSets/

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard setting organizations, and transaction change request system. www.hipaa-dsmo.org

Health Level Seven (HL7)

- HL7 is one of several ANSI accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards. www.hl7.org

Healthcare Information and Management Systems (HIMSS)

- An organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of healthcare. www.himss.org.

MassHealth

- The MassHealth Web site assists providers with MassHealth billing and policy questions as well as provider enrollment support. www.mass.gov/masshealth

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

National Uniform Billing Committee (NUBC)

- NUBC is affiliated with the American Hospital Association, and develops standards for institutional claims. www.nubc.org

National Uniform Claim Committee (NUCC)

- NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)

- OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa/

United States Department of Health and Human Services (HHS)

- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. www.aspe.hhs.gov/admnsimp/

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. http://www.wpc-edi.com/

Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org